DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
BOX 788250
MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 5910.1
Code 0104
28 April 1998

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 5910.1

From: Commanding Officer

Subj: SPACE UTILIZATION

Encl: (1) Space Utilization Relocation Request and Evaluation Form

1. Purpose. To provide information regarding space utilization and the procedures to request relocation of working spaces. To publish the membership and functions of the Space Utilization Committee.

2. Background. Like all other resources, space is a valuable but limited commodity. The necessary changes in services and equipment required to best support customer needs also necessitates changes in the utilization of command spaces. In order to maximize the available space and plan for future requirements, a multidisciplinary committee will review and recommend any proposed changes in space utilization to the Commanding Officer.

3. A change in space utilization is not merely a rearrangement of an office's furniture. It is a change in the nature of the function of the space (even if interdepartmental) such as administration to clinical or clinical to administration.

4. Action

a. Space Utilization Committee shall:

(1) Consist of the following members appointed by the Commanding Officer:

(a) Executive Officer (chair)

(b) Director for Administration

(c) Director for Nursing Services

(d) Director for Medical Services

(e) Director for Surgical Services

(f) Director for Ancillary Services

(g) Comptroller

(h) Command Master Chief

(i) Head, Facilities Management

(j) Safety Manager

(k) Head, Operating Management

(l) Union Representative (ad hoc)

(2) Approve any requests for space changes that cross departmental lines.

(3) Meet monthly or as needed to review and consider requests.

b. Department Heads shall:

(1) Fill out enclosure (1) when requesting a move within a department and route via the Head, Facilities Management, Safety Manager, and Head, Operating Management for approval.

(2) Fill out enclosure (1) when requesting a move that crosses department lines and submit to the Space Utilization Committee via the appropriate Director, Head, Facilities Management Department, Safety Manager, and Head, Operating Management for approval.

c. Directors shall review enclosure (1) for relocation of spaces within their directorate.

d. Head, Facilities Management, Safety Manager, and the Head, Operating Management shall review enclosure (1) for all relocation of spaces.

5. Forms. Space Utilization Relocation Request and Evaluation Form, NH29PALMS Form 5910/1 is available through Central Files.

R. S. KAYLER

Distribution:
List A

THIRD PARTY LIABILITY QUESTIONNAIRE
PRIVACY ACT STATEMENT

1. Authority.
Privacy Act of 1974, 5 U.S.C., 552(a) (1982).
Medical Care Recovery Act, 42 U.S.C., 265l-53 (l982)
Navy Affirmative Claims Regulations, 32 C.F.C., 757 (l984)
Department of Justice Regulations, 28 C.F.R., 43 (1943)

2. Principal Purpose. To provide information for the collection of Medical Care Recovery Act claims against third persons who cause injuries to other individuals who were given medical care at a government health care facility or at government expense.

3. Routine Uses. Information given by the injured persons who received treatment at government expense or at a government health care facility is used to recover the reasonable value of the medical care from the individual who caused the injury. The information is also used to prepare reports to the Department of Justice and the Department of the Navy.

4. Mandatory Disclosure and Consequences of refusal to Disclose. Federal law requires the injured party to provide the requested information. 32 C.F.R., 757.5 (l984); 28 C.P.R., 43.2 (1984); and 42 U.S.A., 2651 (a) (1982).

If the requested information is not given, the United States Navy may force disclosure by court action. The United States Navy may also require the injured person to assign all claims for medical expense of the medical treatment to the United States Navy for collection.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE INSTRUCTIONS AND I DO FURTHER CERTIFY THAT THE ANSWERS ARE TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND COMPLETE. I HAVE ALSO READ AND UNDERSTAND THE CONTENTS OF THE PRIVACY ACT STATEMENT.

_____ _____
(SIGNATURE) (DATE)

(PLEASE PROCEED TO THE NEXT PAGE)

THIRD PARTY LIABILITY QUESTIONNAIRE

Instructions: Please answer all questions as completely as possible. When giving names and addresses, please provide complete addresses, including street number, city, state and zip code. If more space is required for any requested information, please use the reverse side of the sheet.

PLEASE PRINT - - RETURN COMPLETED QUESTIONNAIRE - - DO NOT SEPARETE

1. Name of person injured _____
Home address _____
City _____ State _____ Zip Code _____
Telephone (Home) (___) ____-_____ (Work) (___) ____-_____
Social Security Number _____ Date of Birth _____

(a) If Military Member, current duty station _____
_____ Rank/Rate _____

(b) If Dependent:

Sponsor's Name _____
Sponsor's Social Security _____
Sponsor's Branch of Service _____ Active____ Retired____
Sponsor's Duty Station if Active Duty or home address if Retired _____
Relation to Sponsor _____
Dependent's Social Security Number _____
Dependent's Date of Birth _____

2. Date of accident/incident _____ Time _____
Exact Location (street, avenue, freeway exit, city, state)
_____
_____

(a) Was this accident/incident investigated by a law enforcement agency Yes ___ No ___ If yes, Name and address of agency 9i.e. city police, county sheriff's department, highway patrol) _____
_____ Report Number, if known _____

(b) Circumstances of injury or accident:

(1) Were injuries sustained in a Motor vehicle accident:
Automobile _____
Motorcycle _____
Truck/van _____
Bicycle _____
Public transpiration (bus, train, cab) _____

(PLEASE PROCEED TO THE NEXT PAGE)

(2) Did this accident/incident take place at:
Home _____
School _____
Public Place (i.e. store, restaurant) _____
(3) Was the injured party a pedestrian? Yes __ No __

(4) Other type of incident 9i.e. gunshot, stabbing, fight, dog bite, food poisoning, medical malpractice)
_____

(c) Describe in your own words the circumstances of how this accident/incident took place:

_____
_____
_____

3. Names, locations and dates of treatment received, including all military and civilian hospitals, clinics or other health facilities.

Date(s)	Facility/Doctor	Address/Location

Please indicate if treatment was inpatient or outpatient:

_____
_____

If documentation relating to this incident is available in the outpatient health record, please provide copies.

If injured party is a department or retired service member, did CHAMPUS pay for treatment received? Yes ___ No ___ If Yes, who provide the medical treatment? _____
_____

4. Name and address of party responsible for this accident And/or incident:

Name _____
Address _____
City _____ State _____ Zip Code _____
Telephone (Home) (___) _____-_____ Work (___) _____-_____

(PLEASE PROCEED TO THE NEXT PAGE)

Does the responsible party have insurance? Yes ___ No ___
If yes, provide the below information:
Name of Insurance _____
Address _____
_____
Policy number: _____ File/Claim number: _____

If the injuries sustained were the result of a motor vehicle accident, other party's :
Social Security Number: _____ Date of Birth _____
Drivers license _____ State _____

If the injuries sustained were the result of a motor vehicle Accident, other party's:
Social Security number _____ Date of Birth _____
Drivers license _____ State _____

5. If the injuries sustained were the result of a motor vehicle accident, were you the: Driver ____ Owner ____ Passenger ___

Owner: Name _____ Rank/Rate: _____
Address and/or Duty Station: _____
Social Security Number: _____
City _____ State _____ Zip Code _____
Telephone (Home) (___) ____-_____ (Work) (___) ____-_____
Insurance information:
Company Name _____
Address _____
Policy number: _____ File/Claim number: _____
Type of insurance coverage:
Liability _____ Amount _____
Uninsured Motorist _____ Amount _____
Medical Payment _____ Amount _____
Personal Injury Protection _____ Amount _____

Driver: Name _____ Rank/Rate _____
Address and/or Duty Station: _____
City _____ State: _____ Zip Code _____
Telephone (Home) (___) ____-_____ (Work) (___) ____-_____
Insurance information:
Company name _____
Address _____
_____
Policy number: _____ File/Claim number: _____
Type of insurance coverage:
Liability _____ Amount _____
Uninsured Motorist _____ Amount _____
Medical Payment _____ Amount _____
Personal Injury Protection _____ Amount _____

(PLEASE PROCEED TO THE NEXT PAGE)

6. Do you or any member of your family have any type of insurance covering your injuries? Yes ___ No ___ If yes, Provide the below information:
Name of Insurance _____
Address _____
_____
Name of Policy Holder: _____
Policy Number: _____

7. Did any military members, dependents, and/or retired members sustain injuries as a result of this accident/incident?
Yes ___ No ___ If yes, **provide the name, address, duty station, rank, and social security number.**

(a) _____
_____
_____ SSN _____

(b) _____
_____
_____ SSN _____

(c) _____
_____
_____ SSN _____

8. Have you obtained an ATTORNEY for the recovery of damages?
Yes ___ No ___ If yes, please provide the information requested below:

Name _____
Address _____
City _____ State _____ Zip Code _____

9. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL AND MILITARY RECORDS IN CONNECTION WITH THIS CASE.